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ORIGINAL RESEARCH

The Impact of an Intergroup Dialogue Workshop on Culturally Competent Clinical Behaviors in Athletic Trainers

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Context: Athletic trainers (ATs) possess moderate levels of cultural knowledge and awareness but a lower capacity to demonstrate culturally competent clinical behaviors. Proven educational strategies for improving culturally responsive care have yet to emerge. Intergroup dialogue is a pedagogical approach that may bridge the knowledge-to-practice gap, promote equity, and enhance culturally competent patient care.

Objective: To determine the impact of an intergroup dialogue workshop on cultural knowledge and awareness and on clinical behaviors associated with cultural competence.

Design: Mixed-methods cross-sectional cohort.

Setting: In-person workshop and survey with web-based survey follow-up.

Patients or Other Participants: Sixteen practicing ATs.

Intervention(s): ATs participated in an intergroup dialogue workshop designed to improve cultural competence. Cultural awareness and sensitivity (CAS) and culturally competent behavioral intentions (CCB) were measured quantitatively using a modified Cultural Competence Assessment. Written survey responses recorded participants' workshop experiences and patterns of culturally competent clinical behaviors.

Main Outcome Measure(s): A 2×3 analysis of variance with Tukey post hoc ($P < .05$) calculated differences in the CAS and CCB measurements over time (preworkshop, immediately postworkshop, 6 weeks postworkshop). Written responses were coded to identify common themes, type and frequency of behavior modifications.

Results: The CAS scores were greater postworkshop when compared to preworkshop values ($P = .010$), with no further change 6 weeks postworkshop ($P = 1.00$). The CCB was significantly higher postworkshop ($P < .001$), and then returned to baseline values 6 weeks postworkshop. Qualitatively, however, there was evidence of sustained behavioral change 6 weeks postworkshop, with a majority (11, 69%) of participants reporting clinical behavior changes.

Conclusions: Our results offer initial support for the efficacy of an intergroup dialogue workshop to promote culturally responsive clinical behaviors among ATs. This method may be used by AT educators, coordinators of clinical education, and practitioners to prepare current and future ATs with knowledge and skills to be culturally competent practitioners.

Key Words: Cultural competence, diversity, inclusion, cultural awareness

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KEY POINTS

- Findings corroborate previous research to underline the cultural competence knowledge-to-practice gap and need for cultural competence education in athletic training.
- Results evidence the efficacy of an intergroup dialogue–informed workshop to promote cultural awareness/sensitivity and cultural competence clinical behaviors among athletic trainers.
- Future research should explore the efficacy of long-term, recurring educational initiatives, as cultural competence and intergroup dialogue are ongoing processes.

INTRODUCTION

Culturally competent health care requires that providers "continuously strive to achieve the ability to effectively work within the cultural context of a client (individual, family, community)."[1] Campinha-Bacote's[1] framework suggests that whereas cultural awareness and knowledge underpin culturally responsive patient care, cultural competence is a more involved, ongoing process that consists of 5 interrelated constructs: cultural desire, awareness, knowledge, skill, and encounters. Cultural desire is the motivation to "want to" become culturally competent; cultural awareness requires deep self-examination of one's biases, prejudices, and assumptions; cultural knowledge is the process of seeking education; cultural skill is the ability to collect relevant patient information and perform a culturally sensitive physical exam; and cultural encounters are required face-to-face interactions with diverse patient populations in order to explore differences, establish common ground, self-reflect, and adjust.[1] Health care providers who value diverse perspectives and adopt a culturally competent patient-centered approach consider these factors during patient interactions, thereby improving health outcomes.[2]

In the early 2000s, scholarly publications underscored the need for athletic trainers to improve their working knowledge of critical issues concerning race, ethnicity, religion, sexual orientation, discrimination, and identity.[3–6] Athletic training program educators were also pressed to discover "various and creative strategies for implementing a multicultural agenda."[3] In 2010, the first study assessing athletic trainers' cultural competence revealed moderately high levels of awareness and sensitivity, but lower levels of culturally competent behaviors.[7]

Ensign et al[8] likewise revealed positive attitudes toward lesbian, gay and bisexual athletes, yet noted a continued need for athletic trainers to create a safe and respectful clinical environment for all patients. Subsequently, another study showed that athletic training students also exhibit similar knowledge and clinical practice trends that appear to persist postgraduation.[9] This divide between knowledge and culturally competent clinical practice highlights the need for focused and intentional education that helps athletic trainers develop the practical skills and tools for implementation.

Although accreditation mandates require professional educators to prepare students with a culturally competent patient-centered approach, research indicates that educators may be ill prepared to train students with such skills. Grove and Mansell[10] evaluated athletic training educators' cultural competence and preparedness to teach related concepts. Consistent with practicing athletic trainers and athletic training students, the authors found that educators exhibited higher levels of knowledge but a lower capacity to translate cognitive skills into culturally competent practice. Fewer than half of educators felt they possessed the proper knowledge to teach cultural competence concepts, and the majority had never sought postprofessional continuing education. Moreover, only 21% of athletic training educators reported receiving cultural competence training during their professional education.[10] Professional education is essential to increase athletic trainers' cultural competence, yet students' foundational understanding of these topics appears to rely on many teachers who also lack formal education themselves. Further, although literature clearly supports that diversity training improves cultural competence,[11] there is limited evidence regarding which teaching strategies measurably improve culturally responsive clinical behaviors.

One evidence-based method that holds the potential to bridge this knowledge to practice gap is intergroup dialogue, "an interdisciplinary approach that blends theory and experiential learning to teach people how to communicate across differences."[12] Intergroup dialogue pedagogy consists of 3 components: active learning, structured interaction, and facilitated learning environment. Trained facilitators guide participants through reflection, communication, and experiential activities to examine their own and others' lived and socialized experiences before proceeding to interrogate systems of dominance and social power and foster alliance building.

Facilitators play a critical role in the success of participants' learning experience: they establish a "brave space," which is a group climate that encourages participants to share their own perspectives, consider other people's points of view, and embrace mistakes as learning opportunities.[13] They regularly pose open-ended questions to provoke deep critical thought and self-reflection. Using a 4-stage sequential design, intergroup dialogue curriculum covers a range of concepts (eg, privilege, stereotypes) and helps participants develop practical skills (eg, perspective taking, active listening) to promote inclusion and social justice.[14,15] This approach stems from Gordon Allport's[16] conditions for positive intergroup contact. Allport[16] posited that under specific conditions (eg, equal group status), intergroup contact functions as an effective means to reduce prejudice. As such, a traditional intergroup dialogue approach brings together members of different social identity groups (eg, race, gender) with equal representation to

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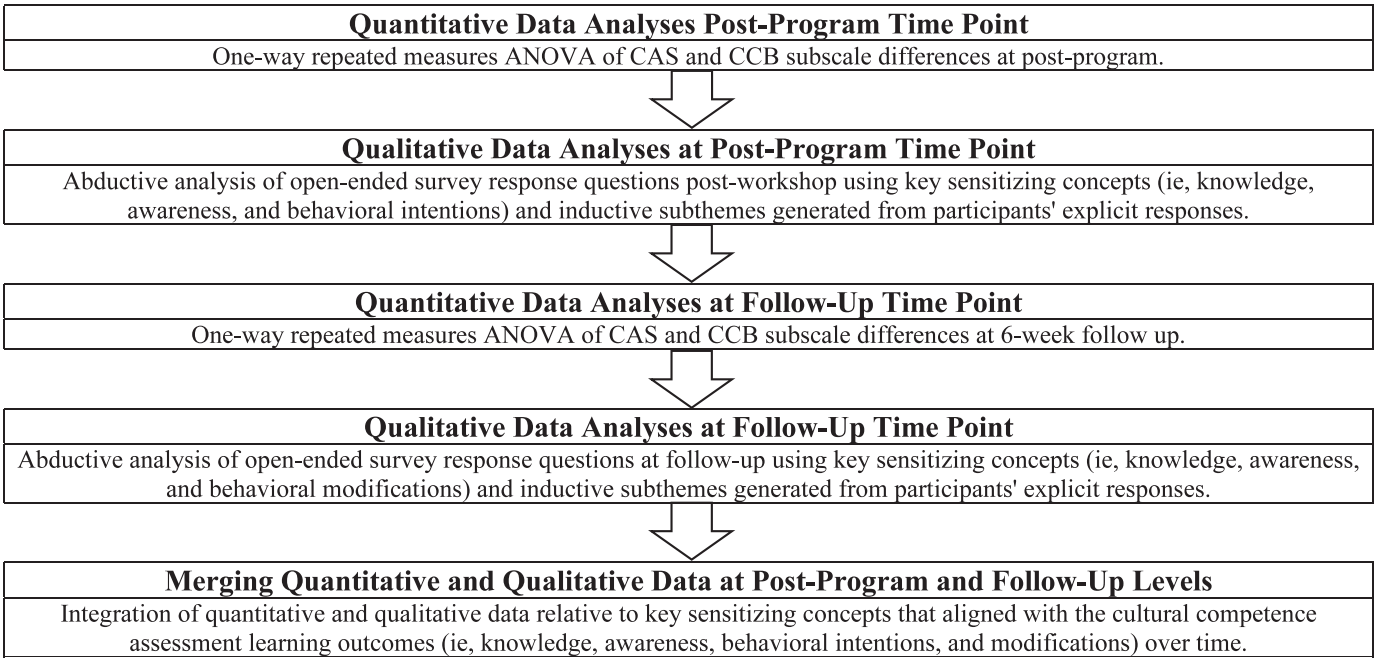
Figure 1. Mixed-methods flowchart of merging quantitative and qualitative data. Abbreviations: ANOVA, analysis of variance; CAS, Cultural Awareness and Sensitivity; CCB, Cultural Competence Behaviors.



balance power for positive intergroup interactions. Although balanced representation is ideal, structuring the dialogic space using a traditional intergroup model is not always feasible, such as when a group/community does not have the diversity required.[17] In a less balanced, intercultural group structure, facilitators must contest the status quo, marginalizing dynamics and ensure that socially marginalized voices are heard so as not to enact existing social inequities and power dynamics.[12]

This method has been used in both undergraduate and medical school education, and past research on intergroup dialogue programming lends support for its positive effects. Undergraduate intergroup dialogue program participants demonstrated increased commitment to assessing personal bias, avoiding stereotypes, challenging others' derogatory comments, and reinforcing culturally supportive behaviors.[14] Medical school students were appreciative of the "in-depth conversation" and showed unanimous support for continuing this method of dialogue-based education.[18]

An intergroup dialogue approach was recently described in detail in the *Athletic Training Education Journal* as a possible educational technique to "equip future and current athletic trainers with critical knowledge, awareness, and skills to provide quality care to athletes with diverse identities."[12] Our study aimed to respond to Kochanek's[12] call to assess the efficacy of an intergroup dialogue approach that advances athletic trainers' capacity to provide culturally competent patient-centered care. The purpose of our investigation was to carry out the example intergroup dialogue workshop outlined by Kochanek[12] and examine the impact of an introductory session on cultural awareness and sensitivity and clinical behaviors in athletic trainers. We hypothesized that an intergroup dialogue workshop would increase cultural knowledge and awareness and translate to changes in clinical behaviors associated with cultural competence.

METHODS

Design

This study used a mixed-methods approach that incorporated theoretically coordinated quantitative and qualitative research to combine the strengths of both data types (eg, established links and in-depth information about variation/context, respectively) to support breadth and depth of understanding of an intervention.[19] This study was grounded in pragmatism, which emphasizes the consequences of research and what works in real practice rather than viewing reality as singular. Such a methodologic approach was suitable in this preliminary assessment of the impact of an intergroup dialogue workshop on participants' learning and possible variations that may characterize its efficacy specific to the professional context of athletic training. This design consisted of quantitative (ie, closed-ended survey questions) and qualitative (ie, open-ended survey questions) data to provide various indicators of program efficacy and in-depth information on participants' program experience and learning application. Figure 1 depicts a flowchart with the steps taken to analyze and incorporate qualitative and quantitative data sources in keeping with a mixed-methods approach. The Standards for Reporting Qualitative Research[20] and Strengthening the Reporting of Observational Studies in Epidemiology[21] criteria were consulted to ensure that comprehensive reporting guidelines were met.

Participants

After approval by the college institutional review board, a convenience sample of athletic trainers were invited via email, social media, and word of mouth to attend an intergroup dialogue workshop. At the start of the workshop, attendees received verbal and written information regarding our study and interested athletic trainers voluntarily provided informed consent. Because we were interested in assessing knowledge as

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Table 1. Workshop Participant Characteristics (N = 16)

Characteristic	No. (%)
Gender	
Female	11 (68.8)
Male	5 (31.2)
Race	
Black	1 (6.3)
White	14 (87.5)
Multiracial	1 (6.3)
Degree level	
Bachelor's	6 (37.5)
Master's	10 (62.5)
AT experience, y	
<5	10 (62.5)
5–10	3 (18.8)
11–15	1 (6.3)
25+	2 (12.5)
Practice setting	
Secondary school	6 (37.5)
College/university	8 (50.0)
Outpatient rehabilitation clinic	1 (6.3)
PRN secondary school/college	1 (6.3)
Current work status	
Full time	13 (81.25)
Part time	3 (18.75)
Previous cultural competence training	
Yes	6 (37.5)
No	10 (62.5)

Abbreviation: PRN, as needed.

well as the application of culturally responsive behaviors in the clinical setting, athletic trainers who were not currently practicing were excluded. A total of 16 practicing athletic trainers (11 women, 5 men) completed our study (Table 1).

Intervention

Intergroup Dialogue Workshop. The intergroup dialogue workshop used in this study closely followed the established curriculum described by Kochanek.[12] To avoid redundancy, a full description of the workshop is not rewritten in this manuscript. See Kochanek[12] for a step-by-step guide for implementing intergroup dialogue in athletic training education and the example 90-minute workshop that was used, including objectives, activity components, group debrief questions, and facilitator notes. In keeping with the identified learning objectives (or workshop themes), our session aimed to help participants develop (1) cultural knowledge (ie, an understanding of concepts related to diversity, inclusion, and identity), (2) cultural awareness/sensitivity (ie, an appreciation for and sensitivity to different individual and societal beliefs, values, perceptions, and experiences), and (3) culturally responsive clinical behaviors (ie, practical skills for a patient-centered, culturally competent athletic training practice). Two trained intergroup dialogue facilitators guided the workshop. One university-trained intergroup dialogue facilitator was a white (cisgender) woman and scholar-practitioner in social justice education in sports. The other facilitator was a Black (cisgender) woman and athletic training master's student who was knowledgeable about diversity, equity, and inclusion and more specially trained in intergroup dialogue pedagogy through peer mentoring.

Outcome Measures

Quantitative Survey. The Cultural Competence Assessment (CCA) is an instrument designed to measure cultural competence among health care providers and staff.[22] The CCA correlates significantly with other accepted instruments with demonstrated test-retest reliability ($r = 0.85$) and construct validity (item loadings > 0.40).[22,23] The 25-item Likert-scale CCA is be broken down into 2 subscales: Cultural Awareness and Sensitivity (CAS) and Cultural Competence Behaviors (CCB).[22]

With author permission (Ardith Doorenbos, PhD, email communication, November 13, 2019), we administered the CCA at 3 time points, including a retrospective preworkshop, postworkshop, and 6 weeks postworkshop. A retrospective pretest is a method that helps to avoid the response-shift effect by allowing participants to reflectively assess their preworkshop levels and therefore more accurately determine the degree of change.[24] Demographics questions were added to include questions relevant to our research and the athletic training profession, such as gender, degree earned, work setting, years certified, and previous cultural competence training. We administered the retrospective pretest and posttest CCA immediately after the workshop. Because the posttest CCA could not assess actual clinical behavior, we revised the CCB questions to gauge behavioral intentions: for example, "I intend to seek information on cultural needs when I identify new people in my work or school," versus "I seek information…" After 6 weeks of clinical practice, the final CCA was administered. For practical purposes, the postworkshop CCA was paper based, whereas the 6-week follow-up was administered via a web-based survey service.

Qualitative Surveys. To gather additional information regarding athletic trainers' workshop experience and any intentions to modify clinical behaviors, supplemental open-ended questions were posed immediately postworkshop (Table 2). After 6 weeks of clinical practice, a different set of open-ended questions mirrored the CCB survey. As an example, the CCB asked participants to quantitatively rate how often they "avoid using generalizations to stereotype groups of people." We also inquired, "Since the workshop, if you have avoided using generalizations to stereotype groups of people, please provide a specific example." These data provided depth of understanding regarding the types of culturally competent behaviors practicing athletic trainers engaged in since the workshop (Table 3). In keeping with research and practical models on learning and pedagogy,[25,26] we selected open-ended questions to gauge participants' knowledge, attitudes, and skills development tailored to the specific content of the workshop. Although not analyzed statistically, face validity was established through an initial screening and feedback from 3 credentialed athletic trainers and 2 trained intergroup dialogue facilitators/social justice educators to ensure that questions were clear and subjectively covered the desired concept.

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Table 2. Postworkshop Open-Ended Survey Questions to Gauge Participants' Workshop Experience

1. Can you describe some of the key concepts or activities that made sense to you and your practice as an athletic trainer?
2. Which concepts were not clearly explained, or did you not find relevant?
3. How, if at all, do you think this workshop has influenced your beliefs about inclusion/diversity in your future work with athletes?
4. How, if at all, has this workshop has changed your views on the importance of addressing diversity and inclusion in your work with patients?
5. Did you have any take-home tools from this workshop that you already use? How do you plan to implement knowledge and strategies in your day-to-day practice that arose from participating in the workshop?
6. Is there anything else you would like to add?

Procedures

After informed consent, attendees participated in the intergroup dialogue workshop and then immediately completed the retrospective pretest (CCA) and posttest assessments (CCA and Table 2 questions) to determine any changes in cultural awareness and sensitivity as well as culturally competent behavioral intentions.

After 6 weeks of clinical practice, cultural awareness and sensitivity and engagement in culturally competent behaviors were assessed (CCA and Table 3 questions) to examine sustained program efficacy.

Data Analysis

The CCA uses a total of 25 questions on a 7-point Likert scale. The subscales, CAS and CCB, consist of 11 and 14 questions, respectively.[22] The means of all questions from each subscale offer scores indicating low to high cultural awareness and sensitivity and low to high culturally competent behaviors, respectively. A score of 1 to 3 indicates low competence, 4 is moderate, 5 is high moderate, and scores ranging from 6 to 7 are considered high.[27] A 1-way repeated-measures analysis of variance with Tukey post hoc test ($P < .05$) was used to assess CAS and CCB subscale differences over time (SPSS version 25, IBM Corp).

Qualitative data were analyzed using an abductive analytical approach to provide nuanced insight into the impact of an intergroup dialogue workshop on participants' learning immediately after the program and at the follow-up.[28] Abductive analysis regards a mix of inductive and deductive reasoning in which theory and practice inform one another. This approach involved bouncing between deductive and inductive analytical methods to gather information about the program specific to predetermined categories of questions that underpin intended learning outcomes (ie, deductive) while using open-ended questions that allowed participants to respond freely and for patterns in the data to emerge naturally (ie, inductive). Open-ended survey questions targeted key sensitizing concepts that aligned with workshop learning outcomes (ie, cultural knowledge/understanding, cultural awareness/sensitivity, and culturally sensitive behavioral intentions or modifications). These deductive workshop themes guided the generation of meaning units, or codes, based on participants' expressed (written) responses related to their learning experience. The lead investigator identified and coded meaning units and then proceeded to organize them into hierarchical themes from specific to broad. To build meaning, the identified meaning units were inductively categorized under the overarching sensitizing concepts.[15] For example, the written responses from participants' surveys that described their motivation to "create a brave space in the athletic training room" or "proactively ask participants about aspects of their identity" immediately after the workshop were inductively coded and subsumed under the theme of "culturally responsive clinical behavioral intentions." The deductive category for behavioral intentions was distinct from the theme of clinical behavioral modifications, which was generated at the follow-up. Inductive codes were generated based on participants' explicit responses that evidenced the culturally responsive clinical behaviors that they took up because of their workshop participation (eg, asking patients about their social identities or goals). Through this abductive analytical process, the lead investigator strove to reach code saturation: to capture a comprehensive range of thematic issues related to the underlying phenomenon (ie, program impact on participants' learning).[29] A final step taken was to order subthemes/themes to solidify coherent thematic frame. And, in line with our pragmatic epistemological orientation, the frequency of participants' common responses was calculated as a practically meaningful way to shed light on the prevalence of culturally responsive clinical behavioral intentions (postprogram) and actual behavior modifications (6 weeks after the workshop).

Several strategies were taken to ensure the trustworthiness of abductive analysis, namely the use of triangulation of data, disconfirming evidence, and critical friends.[30] A first strategy that supported trustworthiness of the data was triangulation of qualitative data sources over time, such as reflected in the alignment of participants' behavioral intentions postprogram and actual behavior modification at the follow-up (eg, learning and actively asking about different aspects of a patient's social identity). Researchers also sought to support trustworthiness through efforts to attend to possible disconfirming evidence through open-ended survey questions (eg, "Which concepts were not clearly explained, or did you not find relevant?")[31] and in accounting for the frequency of expressed responses that, to varying degrees, provided support for the workshops impact on participants' learning and knowledge transference (see Tables 4 and 5). A final iterative strategy used throughout the qualitative analytical process that supported trustworthiness of analyses was the use of 2 critical friends (or peer debriefers). Critical friends challenged the lead investigator's analyses relative to the deductive-inductive generation of hierarchical themes.[31] An initial debrief took place with one critical friend (a research team member and athletic training educator) about their initial impressions after the lead investigator familiarized herself with the data. A second debrief took place with this colleague in the final stages of analyses to review the overarching thematic framework. This critical dialogue served to support trustworthiness of their interpretation through critical questions that guided the lead investigator to consider alternative meanings of their interpretation related to program impact. A second critical friend (other research team member and social

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Table 3. Supplemental Survey Questions Requesting Examples of Culturally Competent Clinical Behaviors 6 Weeks Postworkshop

Since the workshop...
1. If you have included cultural assessments on evaluations, please provide a specific example.
2. If you sought information regarding individuals' cultural needs, please provide a specific example.
3. If you have used additional resources, please provide a specific example.
4. If you have asked patients for their own explanation of health and illness, please provide a specific example.
5. If you have asked patients about their expectations of health services, please provide a specific example.
6. If you avoided using generalizations to stereotype groups of people, please provide a specific example.
7. If you recognized barriers to service, please provide an example.
8. If you removed barriers to service, please provide a specific example.
9. If you have sought feedback from patients about how you related to people from different cultures, please provide a specific example.
10. If you adapted services to individual and group cultural preferences, please provide a specific example.
11. If you changed your documentation to include cultural adaptations and assessments, please provide a specific example.
12. Is there anything else you would like to share?

justice in sport scholar-practitioner) was also involved throughout qualitative data analysis. Critical dialogue took place after the preliminary generation codes (or meaning units) using the deductive sensitizing concepts. This critical dialogue served to support trustworthiness through questioning that ensured consistently coded subthemes (eg, distinguishing between conceptual knowledge and awareness of others' differing beliefs), appropriately coding meaning units under a discrete sensitizing concept, and possible disconfirming evidence (frequency of response).

This critical friend reviewed select representative quotations and meaning units for all possible (sub)themes. Their constructive challenges better ensured the accurate coding of subthemes (eg, differentiating between favorable attitudes toward taking action and actual clinical behaviors performed) and their consistent application.

RESULTS

Quantitative

A 2 (CAS, CCB) × 3 (retrospective-pre, post, 6 weeks post) repeated-measures analysis of variance using the Tukey honestly significant difference test was conducted to determine if cultural awareness/sensitivity (CAS) and behaviors (CCB) changed over time. The analysis revealed a significant main effect for time, $F_{2,30} = 9.50$, $P = .001$, as well as a significant interaction for time and subscales, $F_{2,30} = 22.01$, $P < .001$. The CAS scores rose significantly postworkshop (Cohen $d = 1.07$, 95% CI = 0.23, 1.70) and remained at moderately high levels of awareness and sensitivity 6 weeks post. The CCB scores also rose significantly from moderate levels of behavior to moderately high levels of behavior intentions postworkshop. A large effect size substantiated the practical significance of these results (Cohen $d = 1.47$, 95% CI = 0.56, 2.09) however, postworkshop the mean CCB scores returned to the preworkshop level after 6 weeks of clinical practice (Figure 2).

Qualitative

Abductive analyses of qualitative data from participants immediately postworkshop and at the 6-week follow-up generally showed favorable changes in participants' cultural knowledge, awareness/sensitivity, behavioral intentions, and clinical behaviors because of their dialogue experience. Qualitative results with participants' explicit responses regarding program impact are presented in a temporal fashion below.

Immediately Postworkshop

Immediately after the workshop, qualitative analysis of participants' written responses to survey questions revealed key outcomes in line with workshop learning objectives. Table 4 summarizes data related to the 3 learning outcomes, specifically depicting athletic trainers' intentions to improve cultural knowledge, cultural awareness and sensitivity, and culturally responsive clinical behavioral postworkshop. To demonstrate areas of commonality and variation in participants' feedback about their experience, the "frequencies" column accounts for the number of comments related to each learning outcome.

Regarding the workshop experience, 10 attendees wrote that workshop content was clear and relevant to their work as athletic trainer (6 did not comment). Two participants made specific requests for more time to navigate through additional practical scenarios relating to social identity (eg, inclusive approaches to working with transgender athletes). After the workshop, most participants expressed developing greater levels of "awareness," "respect," "openness" and "understanding of differences." Several participants wrote that the workshop strengthened their views about the significance of asking questions and listening to not make assumptions regarding their patients and adapting to each patient's unique needs. Specifically, one participant responded, "I learned the importance of not assuming peoples' identities, and respecting their preferences," and another participant commented that the program "assisted with not assuming which beliefs are important to others." Participants also elaborated on specific culturally responsive clinical behaviors that they intended to carry out because of their workshop experience. Attendees reported that they intended to ask patients "about identities and beliefs," "be a better listener" and "be more open-minded." One participant uniquely noted that workshop practical skills (eg, gaining perspective by asking open-ended questions and actively listening, and intervening) and tools (eg, PALS acronym with steps to intervene after a derogatory comment: pause, ask for clarification, listen, and speak to your perspective) would help them assist patients to "be more introspective about their identities and cope after injury." In total, over 87% of attendees (n = 14 of 16) wrote that they were inspired to implement the communication skills and tools learned from the workshop activities, with 26 expressed intentions to actively seek knowledge, ask questions, listen,

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Table 4. Summary of Participants' Learning Outcomes and Behavioral Change Intentions Immediately Post–Intergroup Dialogue Workshop

Workshop Learning Outcomes (or Sensitizing Concepts)	Postworkshop Feedback[a]	Postworkshop Behavioral Intentions[b]	Frequency of Behavioral Intentions[c]
Cultural knowledge and understanding Understand concepts related to diversity, identity, and inclusion	• Inspired to understand other cultures • Improved understanding of the term *identity*	• Will seek cultural competence education	1
Cultural awareness and sensitivity Gain an appreciation for and sensitivity to different beliefs, values, and perceptions	Improved: • Awareness of self • Appreciation for differences and the importance of treating others with respect • Understanding that policies must address diversity and inclusion	• Will be more aware of own biases • Will be more open-minded • Will avoid the use of derogatory terms	1 1 1
Culturally responsive clinical behaviors Develop and practice patient-centered strategies and practical tools	Learned: • The importance of active listening • How to intervene and have difficult conversations • How to ask others about their identity, values, and preferences • The importance of "brave space" • The importance of reducing barriers to health care	• Will ask patients about their identity • Will intervene to correct destructive behavior • Will practice active listening • Will create a "brave space" in the athletic training room	12 7 2 1
Total number of expressed behavioral intentions			**26**

[a] Summary of participant's written workshop feedback related to each learning outcome.
[b] Summary of participants' written behavioral change intentions related to each learning outcome.
[c] Represents the number of participants' written comments related to each behavioral change intention.

and intervene to correct disparaging behavior (Table 4). Considered alongside the statistically significant changes on participants' CCA scores, qualitative findings show convergence with quantitative results.

Six Weeks Postworkshop

At the follow-up, 68.8% (n = 11 of 16) of athletic trainers had enacted a total of 38 behavioral changes to improve cultural knowledge and awareness and acknowledged engaging in more culturally competent clinical practice.

Athletic trainers most asked patients about their social identities, discussed needs and goals, and took additional time to clarify patients' understanding of their treatment and plan of care (Table 5). Written comments revealed that athletic trainers actively enhanced their understanding of diversity-related topics via the internet and scholarly articles and felt they had improved their cultural awareness and sensitivity since the workshop. One participant revealed that they corrected themselves before using a derogatory term, and others shared how they worked through language barriers and perceived themselves to be more "culturally aware of foreign exchange students." Participants explicitly mentioned that they were "more diligent in asking how people view their own identities" and "asked questions of the patient to best understand their culture." Workshop participants also cited that they made additional strides to remove barriers to health care in an effort to attend to each patient's needs. On the whole qualitative findings were, in part, convergent with quantitative results (ie, changes in cultural knowledge/awareness). However, the lack of statistically significant change at the follow-up for CCB suggests some divergence from qualitative findings. Beyond what quantitative results could capture, responses from program participants at the follow-up provided more in-depth insight into the clinical behaviors they adopted because of the program.

DISCUSSION

Evidence has consistently supported that athletic training students, practicing athletic trainers and educators alike possess moderate to high levels of cultural awareness and sensitivity that do not necessarily translate into culturally competent behaviors.[7–10] This knowledge-to-practice gap in the field is further exacerbated because educators report a lack of professional training and feel underprepared to teach concepts related to cultural competence.[10] Our study aimed to serve as a preliminary effort to address the critical need for research that assesses educational techniques for cultural competence promotion in athletic training. Our findings offer initial support for the efficacy of a single 90-minute intergroup dialogue–informed workshop to promote cultural awareness and culturally responsive clinical behaviors among athletic trainers.

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Table 5. Summary of Participants' Culturally Competent Behaviors 6 Weeks Post–Intergroup Dialogue Workshop

Workshop Learning Outcomes (or Sensitizing Concepts)	6 Weeks Postworkshop Culturally Competent Behaviors[a]	Frequency of Culturally Competent Behaviors[b]
Cultural knowledge and understanding Understand concepts related to diversity, identity, and inclusion	Sought further understanding via: • Scholarly articles • Internet resources • Books	 1 1 1
Cultural awareness and sensitivity Gain an appreciation for and sensitivity to different beliefs, values, and perceptions	• More mindful of the needs of international patients • More aware of language barriers • Avoided use of derogatory nicknames and stereotypes	2 1 2
Culturally responsive clinical behaviors Develop and practice patient-centered strategies and practical tools	Asked patients: • About their personal and social identity • About their needs, goals, and expectations • For feedback regarding the quality of culturally competent care • About faith • About necessary accommodations	 5 4 2 1 1
	Took time to: • Clarify athlete's understanding of the plan of care • Spend equal time with all patients • Create a safe and comfortable atmosphere • Document culturally competent care • Talk with patient's parents regarding needs	 4 2 1 1 1
	Removed barriers by: • Adjusting care based on financial/insurance barriers (foreign and domestic patients) • Assisting with transportation needs • Working with interpreters to improve communication	 4 2 2
Total number of culturally competent behaviors		**38**

[a] Summary of patients' behavioral changes related to each learning outcome.
[b] Represents the number of participants' written comments related to each culturally competent behavior.

Campinha-Bacote[32] posited that culturally competent health care delivery is an ongoing, aspirational process. He asserted that knowledge and awareness must be coupled with effective training, guided reflection, and cultural skill alongside clinical practice opportunities with diverse patient populations. One persistent barrier to the cultural competence developmental process appears to be a lack of well-described, systematically evaluated behavioral interventions. Scholars[33] have called attention to the need for detailed accounts of theory educational interventions in order to offer practitioners and educators practical guidance to build upon and replicate effective training methods. With this in mind, the intergroup dialogue approach explicitly detailed by Kochanek[12] and used in our study provides a theory-driven, generalizable yet flexible framework that may be developed and adapted to the specific needs of different athletic trainer subgroups. Scholarship in athletic training and related health care fields corroborate pedagogical components central to a dialogic approach for cultural competence promotion among practitioners.[9,34] In intergroup dialogue, sequentially delivered reflective and experiential activities guide critical thought and discussion to help participants consider diverse, nondominant perspectives.

Written responses from our study participants showed that the active, engaging workshop activities supported their critical awareness and skills development. In line with previous research, participants specifically noted the benefit of role-playing using real scenarios to practice culturally responsive behaviors (eg, how to ask questions, actively listen, and interrupt derogatory behavior).[18,35] Several expressed that the scenario-based simulations were helpful, with one remarking, "I liked how we were able to go through the scenarios and put into perspective how patients feel." Another attendee expressed that the workshop activities were "beneficial to get out of our comfort zones and address common issues that we have to face in our profession."

Our quantitative results showed a significant improvement in cultural awareness and sensitivity as well as behavioral intentions immediately postworkshop (Figure 2). Postworkshop qualitative findings converged with quantitative results highlighting specific aspects of participants' cultural competence development (eg, critical awareness and skill building). After 6 weeks of clinical practice, athletic trainers' CAS scores remained above their preworkshop levels, and their CCB scores returned to baseline (Figure 2). On the surface, these quantitative results may suggest that athletic trainers did not carry out their intended culturally responsive clinical behav-

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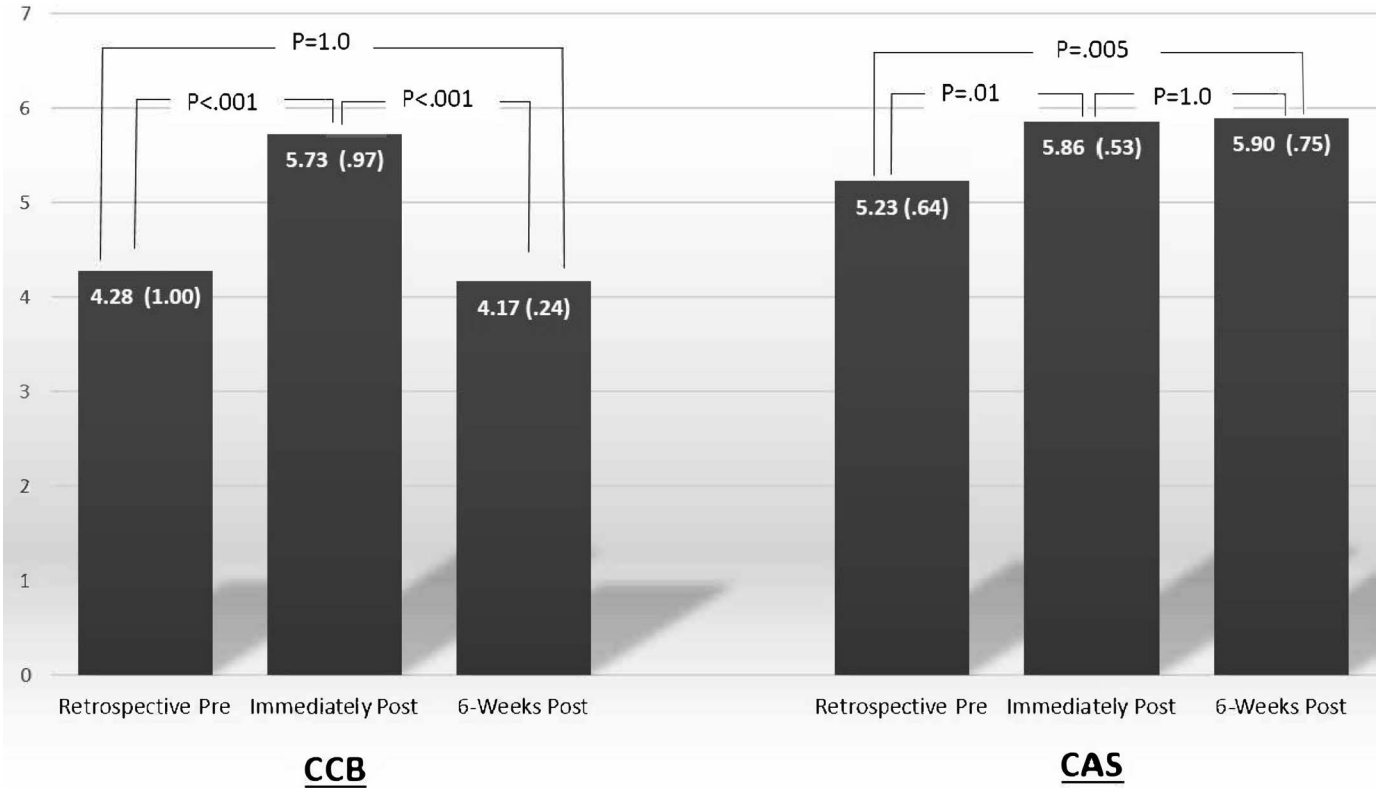
Figure 2. Changes in Cultural Competence Behaviors (CCB) and Cultural Awareness and Sensitivity (CAS) mean scores (SD) over time ($P < .05$).



iors, but our qualitative findings provide more nuanced, information-rich insight on changes in their knowledge, awareness, and clinical behaviors. Six weeks postworkshop, many participants provided multiple examples of culturally competent behaviors they had practiced clinically (Table 5).

Although the long-term impact of a single 90-minute intergroup dialogue workshop is beyond the scope of this preliminary study, sustained behavior changes will likely require sequential, reoccurring experiences to effectively engage athletic trainers in their cultural competence process. The complex, nonlinear, and process-oriented nature of individual behavior change aligns with the extant literature.[36] Although additional evaluative research is necessary, our findings point to intergroup dialogue as a pedagogical strategy that can support the development of cultural knowledge/awareness and culturally responsive action in athletic trainers.

Limitations

As with any novel investigation, our study is not without limitation. First, and as previously acknowledged in athletic training research are the potential constraints of the CCA.[9,10] Although the CCA has established validity for use in other health care professions, the measure is not designed specifically for athletic training. The traditional athletic training clinical setting is unique to other health care professions in that day-to-day patient interactions are often unscheduled, momentary, and urgent. To score high levels of competence on the CCB, participants must answer that they "always" engage in the specified behaviors. This line of assessment less adequately accounts for the practical realities of the fast-paced traditional athletic training environment, because clinicians rarely have the protected opportunity or time to privately interact with every patient in more personal, identity-relevant ways. As a result, sole quantitative analysis via the CCB may not provide full representation of athletic trainers' efforts toward providing culturally competent patient care. The research literature supports mixed-methods and qualitative approaches,[9,11] and our mixed-methods design offered concrete accounts of our participants' self-described experiences and examples of patient-centered care, which lends support for the efficacy of an intergroup dialogue approach to promote cultural competence.

Future Directions

Several future research directions stem from this preliminary assessment of the efficacy of an intergroup dialogue approach to cultural competence promotion in athletic training education. First, future research efforts can explore the impact of an intergroup dialogue workshop among a larger sample of athletic trainers with diverse identities who work in communities with varying demographics. Given that athletic trainers self-selected into the dialogue encounter, the inclusion of individuals who may have a greater range of interest and/or readiness could provide a more comprehensive examination of program efficacy. We did not assess the impact of specific participant characteristics (eg, athletic training experience, degree level, previous cultural competence training) on levels of cultural competence. Hence, evaluation of how dialogue programming may differently impact specific clusters of individuals based on similar baseline levels on intergroup outcome measures (eg, awareness/understanding and attitudes) would be a valuable way to more rigorously gauge learning impact by individual and community context.

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A second research direction is to evaluate the efficacy of a longer educational initiative that engages participants beyond a single session. After longer-term programming, researchers could assess both the learning outcomes and processes that support, or thwart, participants' program experience and learning. Insight into the processes (eg, program features, meaningful/challenging moments) salient to participants' cultural competence development is necessary to better tailor future educational initiatives to meet the unique needs of athletic trainers.

CONCLUSIONS AND APPLICATION TO EDUCATION

Our findings suggest that a dialogue-informed workshop improved cultural knowledge and awareness and provided practical skills that athletic trainers may immediately implement with their patients.

Although one workshop is not sufficient to fully support the ongoing process of cultural competence, these promising results show that the intergroup dialogue approach may have the potential to inform future sustained efforts to adequately engage athletic trainers.

Given the myriad of existing intergroup dialogue programs at universities and colleges across the country, established initiatives and/or resources (eg, facilitators and facilitator-training opportunities) may be more readily accessible than athletic training professionals and decision makers realize. Athletic training educators and leaders can consider pursuing possible within- or cross-campus collaborations with their institution's office of diversity, inclusion, and intercultural initiatives. Programming could be integrated into both professional development and student curricula, not simply as a superficial add-on but as an embedded and foundational element.

Alternative settings such as professional conferences also present opportunities for athletic trainers to participate in and possibly be trained in intergroup dialogue for cultural competence promotion. Although practitioners and program educators have limited time and resource constraints, an intergroup dialogue approach shows great potential as a feasible and effective strategy to empower athletic trainers with knowledge and skills to provide culturally competent, patient-centered care.

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